OHIO UNIVERSAL APPLICATION & CHANGE FORM

GROUP SIZE: 2-50 ELIGIBLE EMPLOYEES

Medical Mutual of Ohio allows groups of one to enroll using this application; Groups of one are permitted to enroll on this application when applying through an alliance.

Brokers or Consultants may send this information to multiple carriers to obtain rates

The Ohio Department of Insurance authorizes the use of this form by the following carriers:

Aetna	AultCare	HealthAmerica	Humana	Medical Mutual of Ohio
• Aetna Health, Inc • Aetna Health Insurance Company • Aetna Life Insurance Company	• AultCare Corporation • McKinley Life Insurance Company	• Coventry Health and Life Insurance Company, d.b.a. HealthAmerica • HealthAmerica Pennsylvania, Inc., d.b.a HealthAssurance HMO		• Medical Mutual of Ohio • Medical Health Insuring Corporation of Ohio • Consumers Life Insurance Company
Paramount	**SummaCare**	**The Health Plan**	**UnitedHealthcare**	
•	•	•	• UnitedHealthcare of Ohio, Inc • UnitedHealthcare Insurance Company of Ohio • United Healthcare Insurance Company • UnitedHealthcare Insurance Company of the River Valley	

Please note: All carriers are independent contractors.

This universal application is intended to simplify your health insurance application process when your employer has requested quotes from multiple carriers. You only need to complete one application when applying for coverage through Aetna, AultCare, HealthAmerica, Humana, Medical Mutual of Ohio, Paramount, SummaCare, The Health Plan, and/or UnitedHealthcare. To ensure your privacy rights, you may be required to sign a separate authorization for each carrier unless you are waiving coverage. If coverage is being waived, only one signature is required (page 4).

Although one application is being used, ultimately, one carrier and its affiliates/subsidiaries selected by the employer will provide the coverage.

This application may not be used for carriers other than those shown above.

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

In completing this application and answering the questions set forth herein, you should not include any of your and/or your dependent's family history or genetic information (including, but not limited to, genetic testing, genetic services, genetic counseling, or genetic diseases for which you and/or your dependents may be at risk).

Ohio Universal Application and Change Form
Group Size: 2-50* Eligible Employees

* Medical Mutual of Ohio allows for groups of 1 to enroll with this application.

Employer Name	Policy/Group #	Section#	Proposed Effective Date

GROUP SPECIFICS	REASON FOR APPLICATION/CHANGE	CARRIER	EMPLOYEE TYPE
Full Time Hire Date: Hours worked/Week: Position: Salary: $ ☐ Weekly ☐ Monthly ☐ Annual	☐ Qualifying Event: reason_____ (date) _____/_____/_____ ☐ New Group Plan ☐ New Hire ☐ Currently covered under Employer's medical plan (Change Benefits) ☐ Open Enrollment ☐ COBRA ☐ Retired ☐ Enroll Dependent ☐ Terminate Subscriber Reason_____ ☐ Terminate Dependent Reason_____ ☐ Name Change (previous name) ☐ Address/Phone/E-mail change ☐ PCP Change	☐ Aetna ☐ AultCare ☐ HealthAmerica ☐ Humana ☐ Medical Mutual of Ohio ☐ Paramount ☐ SummaCare ☐ The Health Plan ☐ UnitedHealthcare	☐ Active ☐ Retired -or- ☐ Cobra COBRA/State Continuation Start date: End date: ☐ Hourly ☐ Union ☐ Non-Union or ☐ Salaried ☐ Other _____ **E-mail Address**

Benefits Administrator Approval:				Date:
Last Name	**First Name, M.I.**	**Social Security Number**	**Home Phone**	**Work Phone**

Home Street Address, Apt. No.	City	State	Zip
Work Street Address	**City**	**State**	**Zip**

Preferred Language (USED AT HOME)	Race (Check all that apply)	Ethnic Background
☐ English ☐ Spanish ☐ Sign (ASL) ☐ Braille ☐ Other_____	☐ White ☐ Black/African American ☐ Asian ☐ Native American/Alaskan ☐ Native Hawaiian/Pacific Islander	☐ Hispanic or Latino ☐ Not Hispanic/Latino

FAMILY INFORMATION: For court-ordered dependent, legal documentation must be attached.

Last Name First Name, MI.	Social Security Number	Relationship	Sex	Birth Date	Height	Weight	Coverage Status	Smoker (Y or N)
Employee PCP Selection (if HMO or POS)_____		Self					☐ Single ☐ Divorced ☐ Married ☐ Widowed ☐ Legally Separated	
Spouse PCP Selection (if HMO or POS)_____		☐ Spouse						
Child PCP Selection (if HMO or POS)_____		☐ Child ☐ Stepchild ☐ Other					☐ Different Last Name ☐ Lives at another address ☐ Full Time Student +19 School Name & Credit Hours Attending _____ ☐ Disabled +19	

Last Name First Name, MI.	Social Security Number	Relationship	Sex	Birth Date	Height	Weight	Coverage Status	Smoker (Y or N)
Child PCP Selection (if HMO or POS)_________________		☐ Child ☐ Stepchild ☐ Other					☐ Different Last Name ☐ Lives at another address ☐ Full Time Student +19 School Name & Credit Hours Attending ___________________________ ☐ Disabled +19	
Child PCP Selection (if HMO or POS)_________________		☐ Child ☐ Stepchild ☐ Other					☐ Different Last Name ☐ Lives at another address ☐ Full Time Student +19 School Name & Credit Hours Attending ___________________________ ☐ Disabled +19	
Child PCP Selection (if HMO or POS)_________________		☐ Child ☐ Stepchild ☐ Other					☐ Different Last Name ☐ Lives at another address ☐ Full Time Student +19 School Name & Credit Hours Attending ___________________________ ☐ Disabled +19	

IMPORTANT: If a dependent does not reside with eligible employee, please provide address on a separate sheet. Please see your employer representative for more information about the qualifications for full-time student status.

Employee Name	Group/Policy #	Social Security Number

PRODUCT SELECTION	Medical	Dental (if applicable)	Life Amount (if applicable)	STD (if applicable	LTD (if applicable)	Waiver
Employee	☐	☐	☐	☐	☐	☐ Yes
Spouse	☐	☐	☐	☐	☐	☐ Yes
Dependents	☐	☐	☐	☐	☐	☐ Yes

For multiple option plans indicate plan selection below

Plan Option Selected	Medical	Dental

Life Insurance Beneficiary Designation (For Employee Only: Must be completed if you applied for Life or AD&D insurance)
If two or more primary beneficiaries are named, and you do not list benefit percentages, proceeds will be paid in equal share to the named primary beneficiaries who survive you. If no primary beneficiary survives you, proceeds will be paid to the contingent beneficiary(ies). If you list benefit percentages, the total must equal 100%. (Employee is the beneficiary of proceeds from spouse or child coverage.)

Primary:	Full Name	Relationship	Benefit %
Contingent:	Full Name	Relationship	Benefit %
Contingent:	Full Name	Relationship	Benefit %

Other coverage information

Does anyone enrolling on this enrollment form have current or prior coverage? ☐ Yes ☐ No

Proof of current or prior coverage must accompany this enrollment form for pre-existing condition credit and if an employee is waiving coverage. Acceptable forms of proof are:

1. Certificate of Creditable Coverage from prior carrier, or
2. Copy of ID card or most recent payroll stub showing medical coverage deduction, or
3. Copy of most recent medical premium bill from prior carrier

Failure to provide Proof of Prior Coverage may subject you or a family member to the full pre-existing conditions limitation with no credit for prior coverage. You may request a Certificate of Creditable Coverage from your prior carrier.

Name of Covered Individual	Carrier Name	Group Number	Effective Date	Termination Date	Work Status
					☐ Active ☐ Retired
					☐ Active ☐ Retired
					☐ Active ☐ Retired
					☐ Active ☐ Retired

Are you or any of your dependents covered by Medicare? ☐ Yes ☐ No Please attach a copy of the Medicare ID card.	Reason: ☐ Over 65 ☐ Disabled ☐ End Stage Renal Disease ☐ Disabled but actively at work	Covered by Part: ☐ A ☐ B ☐ D	Ineligible for or waived: ☐ A ☐ B ☐ D

If yes, Name of Medicare Beneficiary:	Medicare Part A Effective Date: Medicare Part B Effective Date:	Claim Number:

WAIVER OF COVERAGE

I decline coverage for: ☐ Myself ☐ Myself and all dependents ☐ Spouse
☐ Dependent Children: 1. 2. 3. 4.

Declining coverage due to ☐ Spouse's Employer's Plan; Carrier Name or Group Number: _____
☐ Individual Plan ☐ Covered by Medicare ☐ Medicaid ☐ COBRA
Existence of other coverage: ☐ VA Eligibility ☐ Tri-Care ☐ OTHER: _____ ☐ I(we) have no other coverage at this time
☐ Declining Medical Coverage but Retaining Dental

If you are declining enrollment for yourself or your dependents (including your spouse) because of other insurance coverage, you may be able to enroll yourself or your dependents in this plan if: (1) you or your dependents lose eligibility for that other coverage or reach the plan's lifetime benefit maximum; or (2) the employer stops contributing towards your or your dependents' other coverage. However, you must request enrollment within 31 days after the applicable event occurs (other coverage ends, lifetime maximum is met, or employer's contribution ends). If you or your dependent either become eligible for premium assistance or lose eligibility for coverage under the State Children's Health Insurance Program (SCHIP), you will also be able to enroll in this plan. However, you must request enrollment within 60 days after such an event. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

Signature: _____ DATE: _____

MEDICAL INFORMATION			
Employee Last Name	**Employee First Name**		
Employer Name	**Policy/Group #**	**Section#**	**Proposed Effective Date**

Have you or any person listed in Section "Family Information" on page one of this form – consulted with or been examined or treated by any health care professional **during the last 5 years** for any illness, injury, or health condition in any of the categories listed below? If yes, please check the box that most appropriately describes the condition and explain in the table provided. **Please note that, if you leave out or misrepresent information, we may terminate or not renew your coverage, or we may change your premium retroactive to the date your policy became effective.**

1.) Heart/ Circulatory/Vascular

☐ Yes (Check all that apply)
☐ None Applicable

☐ Ablation Cardiac
☐ Anemia Type_____
☐ Aneurysm Location_____
Operated ☐ YES ☐ NO
☐ Angioplasty/Stent DATE _____
☐ Blood Clot/Thrombophlebitis
Location_____
☐ Blood Disorder Type _____
☐ Bypass DATE_____
☐ CAD/Angina/Chest pain
☐ Corotid Artery Disease
Operated ☐ YES ☐ NO
☐ Congestive Heart Failure/(CHF)
☐ Elevated Cholesterol/ Triglycerides
☐ Heart Attack/Disease/(MI)
Date _____
Type_____
☐ Heart Murmur
☐ Heart Valve Disorder
☐ Hemophilia
☐ Hypertension/High Blood Pressure
☐ Irregular Heart Beat/Arrhythmia
Date_____
☐ Pacemaker/ICD Implant
Date _____
☐ Peripheral Vascular Disease (PVD)
☐ Stroke/CVA Date _____
☐ Stroke Deficits ☐ YES ☐ NO
Date_____
Type_____
☐ Varicose Veins
Operated ☐ YES ☐ NO
☐ Other_____

2.) Brain/Nervous System/Neurological

☐ Yes (Check all that apply)
☐ None Applicable

☐ Alzheimer's Disease
☐ Amyotrophic Lateral Sclerosis/Lou Gehrig's Disease
☐ Brain/Head Injury
Complications ☐ YES ☐ NO
☐ Cerebral Palsy
☐ Concussion
☐ Head Injury
☐ Migraines
Last Visit to ER_____
☐ Multiple Sclerosis/MS
☐ Neurological Disability
Type_____
☐ Muscular Dystrophy
☐ Paralysis
Location_____
☐ Parkinson's Disease
☐ Seizures/Epilepsy
Date Diagnosed_____
Date of Last Seizure_____
Grand Mal ☐ Petit Mal ☐
☐ Tumor/Growth/Cyst
Location _____
☐ Other _____

3.) Endocrine

☐ Yes (Check all that apply)
☐ None Applicable

☐ Adrenal Gland
☐ Cirrhosis
☐ Diabetes
Date Diagnosed_____
☐ Diet ☐ Insulin
☐ Oral Medication
☐ Other_____
☐ Complications
Type_____
Last 3 blood sugar readings
_____ _____ _____
☐ Growth Hormones
Date_____
☐ Hepatitis
☐ A ☐ B ☐ C
☐ Other_____
Date _____
Treatment_____
☐ Hypothyroid
☐ Hyperthyroid
☐ Graves Disease
☐ Hashimoto Disease
☐ Liver Disorder
Type_____
☐ Pituitary Disorder
☐ Thyroid Disorder
☐ Tumor/Growth/Cyst
Location_____
☐ Other_____

4.) Lung/Respiratory

☐ Yes (Check all that apply)
☐ None Applicable

☐ Allergies
Injections_____ ☐ YES ☐ NO
How Often_____
☐ Asthma
☐ Mild ☐ Moderate ☐ Severe
☐ Date of Last ER Visit_____
☐ Chronic Bronchitis
# of times per year_____
☐ COPD /Emphysema;
Oxygen ☐ YES ☐ NO
☐ Cystic Fibrosis
☐ Pneumonia Date_____
☐ Sarcoidosis
☐ Sleep Apnea
C-PAP ☐ YES ☐ NO
☐ Tumor/Growth/Cyst
Location _____
☐ Tuberculosis Date_____
☐ Other_____

5.) Ears/Eyes/Nose/Throat/Skin

☐ Yes (Check all that apply)
☐ None Applicable

☐ Acne
☐ Acoustic Neuroma
☐ Burns
☐ 1st Degree ☐ 2nd Degree
☐ 3rd Degree
☐ Cataracts Operated_____
Right Eye _____ Left Eye _____
☐ Chronic Ear Infections
Operated ☐ YES ☐ NO
☐ Chronic Sinusitis
☐ Cochlear Implants
☐ Deafness
☐ Deviated Septum
☐ Eczema
☐ Glaucoma
☐ Psoriasis Injections ☐ YES ☐ NO
☐ Retinopathy
☐ Tumor/Growth/Cyst
Location_____
☐ Other _____

6.) Immune

☐ Yes (Check all that apply)
☐ None Applicable

☐ Chromosomal Disorder
Type_____
☐ Immuno Deficiency
☐ Lupus
☐ Discoid ☐ SLE
Systemic
☐ Scleroderma
☐ Other_____

Have you been treated for or had a positive test result for the conditions below?
☐ AIDS
☐ HIV+

7.) Cancer

☐ Yes (Check all that apply)
☐ None Applicable

☐ Bone
☐ Brain
☐ Breast
☐ Cervical or Uterine
☐ Colon
☐ Leukemia Type_____
☐ Liver
☐ Lung
☐ Lymphoma
☐ Hodgkin's ☐ Non-Hodgkin's
☐ Metastasis to other Organs ☐ YES ☐ NO
☐ Ovarian
☐ Prostate
☐ Skin Type _____
☐ Testicular
☐ Other Type_____
☐ Lymph Node involvement?
YES ☐ NO ☐
IV Chemotherapy
YES ☐ NO ☐
End date_____
Radiation Therapy
YES ☐ NO ☐
End Date_____
Stage_____

8.) Reproductive

☐ Yes (Check all that apply)
☐ None Applicable

☐ Abnormal Pap ☐ YES ☐ NO
Normal Follow up Pap? ☐ YES ☐ NO
Date:_____
☐ Breast cyst or tumor
☐ Breast Implants
Type ☐ Saline ☐ Silicone
☐ Current Pregnancy
Due Date:_____
☐ Multiples Expected
☐ Complications thus far/high risk
☐ Prior History of Complications
☐ Prior Cesarean Delivery
☐ C-Section Planned
☐ Endometriosis
☐ Human Papillomavirus
☐ Infertility
Dates of treatment _____
☐ Menstrual Disorders
☐ Polycystic Ovarian Syndrome
☐ Pregnancy Complications
☐ Sexually Transmitted Diseases
☐ Other_____
Are you or your dependent(s) the parent of a child expected to be born in the next nine months? ☐ YES ☐ NO

9.) Medication

☐ Yes (Check all that apply)
☐ None Applicable

☐ Current Medications (please provide details below to include the name of the medication and condition for which the medication is needed)
☐ Medications Taken Within the Past Year: _____

10.) Transplant

☐ Yes (Check all that apply)
☐ None Applicable

☐ Organ_____ DATE: ____
☐ Stem Cell
☐ Planned / Recommended DATE: _____
☐ Other _____

11.) Birth Defects/Congenital Abnormalities

☐ Yes (Check all that apply)
☐ None Applicable

☐ Birthmarks
☐ Cleft Palate/Lip
☐ Club Foot
☐ Developmental Delay
☐ Down's Syndrome
☐ Heart Lung Malformation
☐ Mental Retardation
☐ Premature Birth Still Receiving Treatment
☐ Skull/Facial or other Physical Deformities
☐ Webbed Fingers/Toes
☐ Other _____

12.) Other

☐ Yes (Check all that apply)
☐ None Applicable

☐ Abnormal Tests or Physical Results
☐ Test Results Pending
☐ Treatment or Surgery Discussed or Advised, Not Yet Done
☐ Wheelchair Bound
☐ Uses of Crutches or Walker
☐ Workers Comp Injury
☐ Chiro Adjustments
☐ Physical Therapy
☐ Occupational Therapy
☐ Speech Therapy

13.) Urinary/Kidney/Bladder	14.) Intestinal/Digestive	15.) Psychological	16.) Bones/Muscles/Joint
☐ Yes (Check all that apply) ☐ None Applicable ☐ Bladder Disorder ☐ Kidney Stones Date_____ Present YES ☐ NO ☐ How Many Passed _____ ☐ Kidney Disorders ☐ Polycystic Kidney Disease ☐ Prostate Disorder Type_____ ☐ ESRD Medicare effective date_____ Dialysis start date_____ ☐ Renal Failure Medicare effective date _____ Dialysis start date _____ ☐ Tumor/Growth/Cyst Location _____ ☐ Other _____	☐ Yes (Check all that apply) ☐ None Applicable ☐ Pancreatitis ☐ Colon Disorder ☐ Diverticulitis ☐ Crohn's Injections _____ YES ☐ NO ☐ ☐ Feeding Tube YES ☐ NO ☐ ☐ Ilieostomy/Colostomy ☐ Open ☐ Closed ☐ Colon Resection ☐ Total ☐ Partial ☐ Open ☐ Closed ☐ Gastric Bypass/Stapling ☐ Gall Stones ☐ Metabolic Disorder Type_____ Operated YES ☐ NO ☐ ☐ Reflux/GERD ☐ Tumor/Growth/Cyst Location _____ ☐ Stomach Ulcer ☐ Ulcerative Colitis Injections _____ Operated YES ☐ NO ☐ ☐ Other _____	☐ Yes (Check all that apply) ☐ None Applicable ☐ ADHD/ADD ☐ Alcohol Abuse ☐ Alcohol Suicide Attempt Date_____ ☐ Anorexia ☐ Bulemia ☐ Drug Abuse ☐ Cocaine ☐ Methadone ☐ Heroin ☐ Marijuana ☐ Morphine ☐ Opiate ☐ Prescription Drugs ☐ Other ☐ Anxiety/Depression ☐ Autism ☐ Bipolar/Manic Depression ☐ Inpatient MH (Mental Health/HospHealth)/Hosp ☐ Current Counseling ☐ Schizophrenia ☐ Suicide Attempt Date_____ ☐ Other _____	☐ Yes (Check all that apply) ☐ None Applicable ☐ Back/Neck Disorder Treatment _____ ☐ Bulging/Herniated Disc Treatment _____ ☐ Congenital Problem ☐ Degenerative Disc Disease ☐ Fibromyalgia ☐ Gout ☐ Chronic Fatigue Syndrome ☐ Implants (REMOVED) ☐ Joint Injury/Replacement Location _____ Arthroscopy Date_____ Replacement Date_____ Arthritis ☐ Rheumatoid Injections_____ YES ☐ NO ☐ ☐ Fracture ☐ Pins, Screws, Plate ☐ Permanent ☐ Temporary ☐ Osteoarthritis ☐ Osetoporosis ☐ Physical Deformity ☐ Prosthetic Device Body Part_____ ☐ Scoliosis ☐ Spina Bifida ☐ Occulta ☐ Cystica ☐ Tumor/Growth/Cyst Location _____ ☐ Other _____

17.) Have you or any of your dependents been told you have any other condition not listed above (please provide details below)? YES ☐ NO ☐
18.) Have you or any of your dependents that will be covered on this plan been hospitalized in the past 24 months (please provide full details below)? YES ☐ NO ☐
19.) Have you or any of your dependents been advised to have an operation and/or further treatment NOT yet performed? YES ☐ NO ☐
20.) Do any of the conditions identified involve the Bureau of Worker's Compensation? YES ☐ NO ☐ if yes claim #_____

If you checked any conditions, have any other medical conditions, or anticipate any future surgeries or procedures not listed above, please explain on next page.

Please give FULL DETAILS for all "Yes" answers (above). if necessary, please attach, date, and sign additional pages for medical explanation details.

Question Number	Person's Name	Condition (include start date of condition)	Types of Treatment (Month/Year)	Medications (oral, injectable, infusion, or inhaled)	Is Ongoing Treatment Needed? If Yes, Please Explain:	Physicians Name

In connection with this application for coverage with the carrier identified below, I certify that I have read, or have had read to me, this completed form, and I realize that any false statement or misrepresentation in this form may result in loss or rescission of coverage. I acknowledge that all claims relating to such false statements or misrepresentations will become my responsibility if incurred after termination or as a result of rescission.

I understand and agree that the carrier will rely upon the above information and answers as the basis for establishing group premium rates for health care coverage.

I authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurer(s) HMO(s) or other organization, institution or person that has any knowledge of my health or the health of my spouse and/or dependents as listed on this form to disclose such information to the extent permitted by law to this carrier for the purpose of compiling an accurate evaluation of this form and to establish group premium rates for the group. This authorization does not permit the use or disclosure of psychotherapy notes. Authorization to disclose information for the payment of claims is valid for the term of coverage and in connection with application for coverage, policy reinstatement or a request for change in policy benefits, this authorization shall be valid for thirty (30) months from the date shown below.

I understand that I may be contacted by the carrier to obtain additional follow-up information on health conditions disclosed in this document for me and/or my covered dependents.

I understand that I or my authorized representative may receive a copy of this authorization upon request. I agree that a photographic copy of this authorization shall be as valid as the original.

I understand that I may be required to sign a separate disclosure statement for the carrier.

Check name of carrier:

☐Aetna ☐AultCare ☐HealthAmerica ☐Humana ☐Medical Mutual of Ohio ☐Paramount ☐SummaCare ☐The Health Plan ☐UnitedHealthcare

Signature: _____ Phone: (____)_____ Date: _____